MDR Tracking Number: M5-04-1785-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on February 19, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits (99212, 99213 & 99214), therapeutic exercises (97110), electrical stim (97032), hot/cold pack therapy (97010), manual therapy technique (97140), neuro re-education (97112) and myofascial release (97250) for dates of service 07/23/03 through 08/29/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On June 14, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

- CPT Code 99080-73 for date of service 08/18/03. The carrier denied this code with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Therefore, per Rule 129.5 reimbursement in the amount of $15.00 is recommended

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 08/18/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 30th day of September 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

May 21, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1785-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ------. The patient reported that while at work he injured his low back. The patient was initially evaluated with x-rays and treated with medications. The patient was then referred for physical therapy that included resistance stretching and exercises, cervical/lumbar stabilization, closed kinetic chain activities with spinal stabilization, active range of motion, cardiovascular conditioning, neuromuscular/balance/proprioceptive reeducation and manual therapy techniques. The patient continued with complaints of pain and was then referred to a pain management specialist. He then underwent a series of three epidural steroid injections in the lumbar spine, followed by post injection therapy. A discogram performed on 7/8/03 was reported to be abnormal and the patient was recommended for surgery. The patient continued therapy consisting of myofascial release, therapeutic exercises, electrical stimulation, hot/cold packs, manual therapeutic technique, and neuro reeducation.

Requested Services

OV, ther exer, elec stim, hot/cold pack ther, man ther tech, neuro reed, and myofas rel from 7/23/03 through 8/29/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Response to peer review 9/30/03
2. Discogram 7/8/03
3. Progress notes 2/26/03 – 10/20/03

Documents Submitted by Respondent:

1. No Medical Documents submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 36 year-old male who sustained a work related injury to his lower back on ------. The ------ chiropractor reviewer indicated that an electrodiagnostic evaluation performed on 3/18/03 revealed acute radiculopathy of the left L5 nerve root, a discogram performed on 7/8/03 was reported to be abnormal for L4-5, and that lumbar x-rays performed on 7/8/03 showed a partially lumbarized S1, minimal dextroscoliosis and mild spondylosis and facet arthropathies. The ------ chiropractor reviewer noted that the patient has received physical therapy treatment, medical treatment, diagnostic testing and chiropractic treatment. The ------ chiropractor reviewer explained that after one month of treatment, the patient remained symptomatic and referred for epidural injections that were reported to have given the patient about 60% relief. The ------ chiropractor reviewer noted that throughout treatment, the patient complained mainly of back and/or radicular pain that began initially, however months later was still present. The ------ chiropractor reviewer indicated that the patient demonstrated the same objective findings and received, essentially, the same modalities of treatment. The ------ chiropractor reviewer noted that the patient did not receive long lasting benefit from chiropractic treatment and had exceeded a reasonable prognosis. The ------ chiropractor reviewer explained that per The American College of Orthopedic and Environmental Medicine guidelines, massage, diathermy, cutaneous laser treatment, ultrasound, and TENS unit have not been proven effective for acute low back symptoms. The ------ chiropractor reviewer also explained that per Mercy guidelines, a course of two weeks each of two different manual procedures, for a total of 4 weeks should be tried. The ------ chiropractor reviewer indicated that if there is no documented improvement with treatment, manual procedures are no longer required. The ------ chiropractor reviewer explained that treatment for this patient's condition has exceeded a reasonable prognosis and guidelines.
Therefore, the ------ chiropractor consultant concluded that the ov, ther exer, elec stim, hot/cold pack ther, man ther tech, neuro reed, and myofas rel from 7/23/03 through 8/29/03 were not medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department